

Child & Adolescent Service System Program



CASSP COMMUNITY TEAM REFERRAL FORM (revised 12/12/08)

I. Identifying Information

CHILD:

Name: _____ Date of Birth _____ Age: _____ Gender: _____
 Address: _____ City _____ State PA Zip _____
 Who has primary physical custody? _____ Relationship: _____ Current Custody Order? _____ Protection from Abuse Order? _____
 Home Phone: _____ Work/Cell Phone: _____ E-mail address: _____

Does the child have insurance? No Yes If Yes, please indicate if the insurance is Private Public (medical assistance)

MOTHER: (please select) Birth Step Foster Adoptive Other Primary Caregiver

Name: _____ Phone: _____

Address: _____ City: _____ State: PA Zip: _____

FATHER: (please select) Birth Step Foster Adoptive Other Primary Caregiver

Name: _____ Phone: _____

Address: _____ City: _____ State: PA Zip: _____

SIGNIFICANT SUPPORTS/OTHERS: If not listed above (biological family members, extended family, friends, pastors, etc.)

| Name | Age | Relationship to child | In/Out of home | Invite to meeting |
|------|-----|-----------------------|----------------|-------------------|
| | | | | |
| | | | | |
| | | | | |

II. Referral Source:

Referring Agency: _____ Contact Person: _____

Address: _____ City: _____ State: PA Zip: _____

Business Phone: _____ Fax Number: _____

Referring Date: _____

Reason for Referral (place X): _____ Referral to Service(s) _____ Coordination of Services _____ At Risk Cordero/Cordero _____ Other _____

Anticipated outcome of CASSP referral: _____

III. Educational Information:

Current School: _____ Home District: _____

Current School Address: _____ City: _____ State: PA Zip: _____

Contact(s): Name: _____ Phone: _____

Name: _____ Phone: _____

A. School Placement:

| | | | | | | | |
|--------------------------|-------------------|--------------------------|---------------------------------------|--------------------------|---------------------------------|--------------------------|-----------------------|
| <input type="checkbox"/> | Regular Education | <input type="checkbox"/> | Learning Support/Emotional Support | <input type="checkbox"/> | Adult Education/GED | <input type="checkbox"/> | Gifted |
| <input type="checkbox"/> | Home School | <input type="checkbox"/> | Homebound | <input type="checkbox"/> | Life Skills Support | <input type="checkbox"/> | Vocational/Technical |
| <input type="checkbox"/> | Cyber School | <input type="checkbox"/> | Partial Hospitalization/Day Treatment | <input type="checkbox"/> | Currently Not in School/Refusal | <input type="checkbox"/> | Alternative Education |
| <input type="checkbox"/> | Other: _____ | | | | | | |

Does child have IEP? (Please check)

YES

NO

Date of Last IEP:

Current Grade:

Does the child have a 504 plan? (Please check)

YES

NO

Date of last Plan:

Was the child referred to Student Assistance Program?

YES

NO

If the child was referred to Student Assistance Program, what were the recommendations?

IV. Child and Family Profile:

| | | | | | | |
|----------------------------------|--------|----------|----------|-------------|--|--|
| What are your child's strengths? | Kind | Polite | Helpful | Funny/Humor | | |
| | Loving | Artistic | Creative | Social | | |

| | | | | | |
|-----------------------------------|--------------|------------------|---------------------|-----------------------|------------------------------------|
| What are your family's strengths? | Close Knit | Supportive | Works well together | Family lives nearby | Strong spiritual/religious beliefs |
| | Large family | Has fun together | Extended family | Involved in community | |

| | | | | | |
|--|---------------|--------------|-------------|-----------|------------|
| What do you see as your child's needs? | Developmental | Trauma | Educational | Supports | Behavioral |
| | Medical | Social needs | Legal | Emotional | |

| | | | | | |
|---|-----------|---------------------------|--------------|--|--|
| What do you see as your family's needs? | Legal | Vocational/ Employment | Housing | | |
| | Financial | Transportation | Recreational | | |

What does your child do for fun or recreation?

What activities do you participate in as a family?

Do you have family traditions/ rituals/beliefs/customs?

Does your child participate in your family's traditions, share beliefs, customs?

How would you describe your child's friendships?

How would you describe your child's relationships with adults/authority figures? _____

Is there anything else you would like to share about your child or family? _____

Does child or other family members have problems, such as those listed below, which may impact the life of the referred child?

| Family Member (Please place an X in box) | Mental Health Problems? | | Was treatment received? | | | Drug or Alcohol Problems ? | | Was treatment received? | | | Health Problems ? | | Was treatment received? | | | Legal Involvement ? | | Was treatment received? | | | |
|---|-------------------------|----|-------------------------|----|--------|----------------------------|----|-------------------------|----|--------|-------------------|----|-------------------------|----|--------|---------------------|----|-------------------------|----|--------|--|
| | Yes | No | Yes | No | Unsure | Yes | No | Yes | No | Unsure | Yes | No | Yes | No | Unsure | Yes | No | Yes | No | Unsure | |
| Child | | | | | | | | | | | | | | | | | | | | | |
| Mother/Step mother | | | | | | | | | | | | | | | | | | | | | |
| Father/Step father | | | | | | | | | | | | | | | | | | | | | |
| Grandparents/Step | | | | | | | | | | | | | | | | | | | | | |
| Siblings/Step/Half | | | | | | | | | | | | | | | | | | | | | |
| Aunt/Uncle | | | | | | | | | | | | | | | | | | | | | |
| Partner/Paramour | | | | | | | | | | | | | | | | | | | | | |

| | | | | | |
|------------------------|---------------------|--------------------------|---------------|-------------------------|---------------|
| Is there a history of: | Child Neglect | Domestic Violence | Legal System: | Custody Courts | Child Welfare |
| | Trauma | Sexual Abuse/Molestation | | Probation Services | |
| | Physical Abuse | Emotional Abuse | | Criminal Justice System | |
| | Change in residence | Change of Residence | | Child Welfare | |

V. Referred Child's Mental Health Profile (if known)

| | | | | | |
|-----------|--|--|--|--|------|
| Axis I | | | Current Medications: Please specify name, dose, and frequency. | | |
| Axis II: | | | | | |
| Axis III: | | | Prescribing Physician: | | |
| Axis IV: | | | Address: | | |
| Axis V: | | | Phone: | | FAX: |
| GAF: | | | Are there any other medical conditions? | | |

Therapist/Counselor: _____ Date of last evaluation: _____

VI. Service Utilization

A. Inpatient Hospitalizations in past year? Yes No If Yes: Where: _____ When: _____

B. Respite Placements in the past year? Yes No If Yes: Where: _____ When: _____

C. Other Mental Health Services:

| Type of Service: | Contact Name(s): | Address: | Phone: | Dates of Service: | Invite to Meeting? | |
|---------------------------------|------------------|----------|--------|-------------------|--------------------|----|
| | | | | | Yes | No |
| Outpatient: | | | | | | |
| Family Based: | | | | | | |
| Residential Treatment Facility: | | | | | | |
| Partial Hospitalization: | | | | | | |
| Inpatient: | | | | | | |
| School Based Counseling: | | | | | | |

| Type of Service: | Contact Name(s): | Address: | Phone: | Dates of Service: | Invite to Meeting? | |
|----------------------------------|------------------|----------|--------|-------------------|--------------------|----|
| | | | | | Yes | No |
| Multi-system therapy (MST): | | | | | | |
| Casemanagement: | | | | | | |
| Student Assistance Program: | | | | | | |
| BHRS (wraparound) | | | | | | |
| CRR/therapeutic foster care/home | | | | | | |
| Strength Based Therapy | | | | | | |
| Drug & Alcohol | | | | | | |

E. Other Systems:

| Type of System: | Contact Name(s): | Address: | Phone: | Dates/Types of Service: |
|--|------------------|--------------------------|--------|--|
| Westmoreland County Children's Bureau: | | | | |
| Juvenile Justice: | | | | |
| | | | | |
| Has the child ever had legal charges filed against him/her? (Please X) | | <input type="checkbox"/> | No | <input type="checkbox"/> Yes; Please explain |
| | | | | |
| | | | | |
| Other: | | | | |

VII. Referral Source Signature:

I helped complete the CASSP Community Team Referral Form and my signature(s) below acknowledges that the information stated above is accurate to the best of my ability. My signature also acknowledges that the parent(s), guardian(s), and/or the child(ren) assisted in the completion of this form.

Signature of Referral Source Date Signature of Parent(s) and or Guardian Date Signature of Child (if over 14 yrs.) Date

Authorization to Release Information

We, the undersigned, hereby give our consent for the exchange and discussion of the confidential information concerning my/our family at the CASSP Team Meeting which includes core team members and other involved parties. Core Team members include representatives from child welfare, juvenile justice, mental health/mental retardation, case management, education, drug and alcohol and other agencies that serve children and families. I/We also give consent to the members who represent the agencies checked (X) below to facilitate a discussion and sharing of information for the purposes of the CASSP team meeting.

| | |
|----------|---|
| X | Westmoreland County CASSP Coordinator and Representatives /CASSP Team members |
| X | Westmoreland County Behavioral Health/Developmental Services |

- I/We understand that this consent is granted only for a period of **one (1) year** from the date signed.
- I/We understand that I/we have the right to revoke this Authorization at any time.
- I/We may not revoke it to the extent that **Westmoreland County BH/DS** has already relied upon it. In order to revoke this Authorization, I/we understand that I/we must revoke it in writing to **Westmoreland County BH/DS**. (Forms are available for your use if you wish to revoke this Authorization at any time before it expires.)
- I/We understand that information used or disclosed under this Authorization could potentially be re-disclosed by the person receiving the information, and may no longer be subject to the privacy protections provided to me/us by law.

Authorized Signatures:

Client: _____ **Date:** _____ **Parent/Guardian:** _____ **Date:** _____

Witness: _____ **Date:** _____ **Other Responsible Party/Relative:** _____ **Date:** _____